3.1-A Limitation
#7c. Home Health Services
(medical supplies, equipment and appliances)

Oxygen

Oxygen and oxygen delivery equipment are limited and some require medical necessity documentation.

Medical Supplies

1. Medical necessity or prior authorization documentation are required for provision of certain medical supplies which are specified by the Division of Medical Programs.
2. Medical supplies must be necessary and reasonable for treatment of the patient's illness or injury.
3. Medical supplies must be appropriately prescribed by qualified providers of service specified by the Division of Medical Programs.
4. Medical supplies are to be used in the patient's home.
5. Medical supplies provided as a home health service must be necessary for providing the home health service.

Nutritional Replacements and Intravenous Medications

DME services provided for parenteral administration of total nutritional replacements and intravenous medications in the recipient's home require the participation of nursing services from a local home health agency. In areas not served by a home health agency, the services of a local health department or advanced registered nurse practitioner are required.

Refer also to the General Limitations page.

Attachment 3.1-A
#7.d.

Limitations of Physical Therapy, Occupational Therapy or Speech Pathology and Audiology Services Provided by a Home Health Agency or Medical Rehabilitation Facility

Physical, occupational, speech and other therapy services must be rehabilitative and restorative in nature, provided following physical debilitation due to acute physical trauma or physical illness, and must be prescribed by the attending physician. These therapy services are limited to 6 months from the first date of service.

Restorative aide services are limited to those provided under the direction of a registered physical therapist. Restorative aide services must be rehabilitative and restorative in nature, and provided following physical debilitation due to acute physical trauma or physical illness. Restorative aide services are limited to six months' duration. Restorative aide services are noncovered on the same date of service as home health aide services for the same recipient.

Clinic Services Limitations

Ambulatory Surgical Centers

1. Ambulatory surgical center services are limited to procedures approved by the Division of Medical Programs. Only medically necessary surgical procedures are covered with the exception that elective sterilization procedures are covered.

2. Refer to limitations described in Attachment 3.1-A, #5 (Physician Services), and #10 (Dental Services).

Local Health Departments

1. Home health skilled nursing services.

   a. Home health skilled nursing services are covered only if located in a county not served by a home health agency meeting Medicare requirements.
   b. Home health skilled nursing services require a plan of treatment developed by a physician, and certification by a physician that home health services are needed.
   c. Home health skilled nursing services must be provided by a registered nurse.
   d. Medical supplies include but are not limited to dressing materials, disposable syringes, colostomy supplies and catheter supplies.

2. Family planning services.

   a. Initial family planning visits are limited to one per recipient.
   b. Annual family planning visits are limited to one per 12 months.
   c. Interim family planning visits are limited to three per 12 months.

3. The medical components of prenatal care are covered by designated local health departments.

4. Health promotion and risk reduction for pregnant recipients are limited to the following components:

   a. Risk assessment by a nurse.
   b. Confirmation of participation in or referral to prenatal care.
   c. Report to medical provider of recipient's participation in the program.
   d. Report to recipient on identified risks and suggested remedial measures.
   e. Referral to appropriate support services.
   f. Follow-up contact once each trimester following initial contact.
   g. Counseling and teaching in at least three face-to-face contacts.
   h. Nutrition visits for pregnant women who meet nutrition risk criteria.

Substitute per letter dated 11/13/96"

KANSAS MEDICAID STATE PLAN

Replacement Page
Attachment 3.1-A
#9., page 2

Clinic Services Limitations

Local Health Departments, Con'd.

5. Laboratory services and immunizations are limited to a state agency-approved listing.

6. Home visits to the newborn are limited to one per consumer within 28 days after the birth date of the infant and must be performed by a registered nurse.

7. Screening, diagnosis and treatment of sexually-transmitted diseases are covered, with the exception of testing for Acquired Immune Deficiency Syndrome which is free of charge.

8. Nursing assessments must be performed by registered nurses.

9. See Attachment 3.1-A, #4.b. for Clinic services limitations for children under 21 years of age.

Maternity Centers

1. Maternity center services are limited to those provided by state-licensed centers.

2. Services are limited to normal labor and delivery.

Dental Services Limitations

Services for non-EPSDT participants are limited to:

Medical procedures as follows:

a) Orcantral fistula closure;
b) unilateral radical antrotomy;
c) biopsy of oral tissue;
d) radical excision of lesion;
e) excision of tumors;
f) removal of cysts and neoplasms;
g) partial ostectomy, guttering or saucerization;
h) surgical incision for drainage of abscess, removal of foreign bodies, skin, subcutaneous areolar tissue, metal plates, screws or wires, sequestrectomy for osteomyelitis, and maxillary sinusotomy for removal of tooth fragment or foreign body;
i) treatment of fractures;
j) closed reduction of dislocation, limitation of motion and related injections;
k) sutures;
l) oral skin grafts;
m) frenulectomy;
n) excision of pericoronal gingiva;
o) sialalithotomy;
p) excision of salivary gland;
q) sialodochoplasty;
r) closure of salivary fistula;
s) emergency tracheotomy;
t) first 30 minutes of general anesthesia, including materials and apparatus;
u) professional visits of consultation and hospital call; and
v) limited prior authorized medical procedures.

3.1-A Limitation

#11a Physical Therapy Services

Physical therapy services must be rehabilitative and restorative in nature and provided following physical debilitation due to acute physical trauma or illness and must be prescribed by the attending physician.

Physical therapy services are limited to services provided by a hospital, home health agency, approved day treatment program, or physician.

Refer also to General Limitations page.

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3.1-A Limitation

#11b Occupational Therapy Services

Occupational therapy services must be rehabilitative and restorative in nature and provided following physical debilitation due to acute physical trauma or physical illness and must be prescribed by the attending physician.

Occupational therapy services are limited to services provided by a hospital, home health agency, or approved day treatment program.

Occupational therapy must be provided by an occupational therapist registered with the American occupational therapy association.

Refer also to the General Limitations page.

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KANSAS MEDICAID STATE PLAN

Speech, Hearing and Language Services Limitations

Speech and Language Services

1. Speech and language therapy services must be rehabilitative and restorative in nature, and provided following physical debilitation due to acute physical trauma or illness. They must be prescribed by the attending physician.

2. Speech and language therapy services are limited to services provided by a hospital or a home health agency.

3. Speech therapy must be provided by a speech pathologist who has a certificate of clinical competence from the American Speech and Hearing Association.

Hearing Services

1. All hearing aids, dispensing and replacements require prior authorization.

2. Services for the hard of hearing are limited to ear examinations by a physician, audiological testing and evalution by an audiologist or certified hearing aid dealer, dispensing and fitting of hearing aids, hearing aid repair, trial rental of a hearing aid and hearing aid supplies provided by a certified hearing aid dealer.

3. Provision of a binaural hearing aid requires specific documentation of medical necessity supporting significant bilateral loss of hearing and that the patient is legally blind.

4. Reimbursement for hearing aids incorporated into eyeglasses is limited the fitting and dispensing of the hearing aid.

5. Hearing aid repairs costing less than $15.00 are noncovered services. Repairs costing between $15.00 and $75.00 are covered. Repairs exceeding $75.00 are covered only with prior authorization.

6. Trial rental of a hearing aid is limited to one month's duration.

7. Provision of hearing aid batteries is limited to six per month for monaural aids and twelve per month for binaural aids.

Speech, Hearing and Language Services Limitations

Hearing Services, continued

8. Hearing aids may be replaced every four years if a medical examination documents the necessity for replacement. Lost, broken or destroyed hearing aids will be replaced one time during a four year period provided the documentation of the circumstances adequately supports the need and prior authorization is obtained.

Prescribed Drugs Limitations

Effective January 1, 1991, the Kansas Medicaid Program covers outpatient drugs, in accordance with Sections 1902(a)(54) and 1927 of the Social Security Act, which are covered by a national or State agreement, with the following restrictions or exceptions (as indicated by checkmark).

✓ A. Prior authorization program which complies with Section 1927(d)(5) of the Social Security Act.

✓ B. The following drugs are covered, or restricted, as indicated by the checkmark:

✓ 1. Certain drugs are not covered if the prescribed use is not for a medically accepted indication, as defined by Section 1927(k)(6).

✓ 2. Drugs subject to restrictions pursuant to an agreement between a manufacturer and this State authorized by the Secretary under 1927(a)(1) or 1927(a)(4).

✓ C. The following drugs or classes of drugs, or their medical uses, as indicated by a checkmark, are excluded from coverage or otherwise restricted:*

✓ 1. Agents when used for anorexia or weight gain.*

✓ 2. Agents when used to promote fertility.*

✓ 3. Agents when used for cosmetic purposes or hair growth.*

✓ 4. Agents when used for symptomatic relief of cough or colds.*

✓ 5. Agents when used to promote smoking cessation.*

✓ 6. Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.*

✓ 7. Nonprescription drugs.*

✓ 8. Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or his designee.